U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Centers for Disease Control and Prevention (CDC)
Atlanta, Georgia 30333

TYPHOID FEVER SURVEILLANCE REPORT

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

CDC NO.: (1-5) _____

Form Approved OMB No. 0920-0009

Instructions:
– Please complete this form only for new, symptomatic, culture-proven cases of typhoid fever. –

DEMOGRAPHIC DATA

1. Reporting State: _____ (6-7)

2. First three letters of patient's last name: _____ (8-10)

3. Date of birth: Mo. _____ Day _____ Yr. _____ (11-16) *or* Age: (in years) _____ (17-18)

4. Sex: (19) 1 ☐ Male 2 ☐ Female

5. Does the patient work as a foodhandler? (20) 1 ☐ Yes 0 ☐ No 9 ☐ Unk.

6. Citizenship: (21) 1 ☐ U.S. 8 ☐ Other: _____ 9 ☐ Unk.

CLINICAL DATA

7. Was the patient ill with typhoid fever? (fever, abdominal pain, headache, etc) (22) 1 ☐ Yes 0 ☐ No 9 ☐ Unk.

If Yes, give date of onset of symptoms: Mo. _____ Day _____ Yr. _____ (23-28)

8. Was the patient hospitalized? (29) 1 ☐ Yes 0 ☐ No 9 ☐ Unk.

If Yes, how many days was the patient hospitalized? Days _____ (30-31)

9. Outcome of case: (32) 1 ☐ Recovered 2 ☐ Died 9 ☐ Unk.

LABORATORY DATA

10. Date *Salmonella typhi* first isolated: Mo. _____ Day _____ Yr. _____ (33-38)

Site(s) of isolation: *(check all that apply)* (39)
1 ☐ Blood 2 ☐ Stool 3 ☐ Gall bladder 8 ☐ Other (specify): _____ (40-55)

11. Was **antibiotic sensitivity testing** performed on this (these) isolate(s) at the laboratory? *(Please contact the clinical laboratory for this information)* (56) 1 ☐ Yes 0 ☐ No 9 ☐ Unk.

If Yes, was the organism **resistant** to:
- Ampicillin: (57) 1 ☐ Yes 0 ☐ No 9 ☐ Not tested
- Chloramphenicol: (58) 1 ☐ Yes 0 ☐ No 9 ☐ Not tested
- Trimethoprim-sulfamethoxazole: (59) 1 ☐ Yes 0 ☐ No 9 ☐ Not tested
- Fluoroquinolones (e.g., Ciprofloxacin): (60) 1 ☐ Yes 0 ☐ No 9 ☐ Not tested

EPIDEMIOLOGIC DATA

12. Did this case occur as part of an outbreak? (two or more cases of typhoid fever associated by time and place) (61) 1 ☐ Yes 0 ☐ No 9 ☐ Unk.

13. Did the patient receive typhoid vaccination (primary series or booster) within **five years** before onset of illness? (62) 1 ☐ Yes 0 ☐ No 9 ☐ Unk.

If Yes, indicate type of vaccine received: Year received:
- Standard killed typhoid shot (Wyeth-Ayerst): (63) 1 ☐ Yes 0 ☐ No 9 ☐ Unk. _____ (64-65)
- Oral Ty21a or Vivotif (Berna) four pill series: (66) 1 ☐ Yes 0 ☐ No 9 ☐ Unk. _____ (67-68)
- ViCPS or Typhim Vi shot (Pasteur Merieux): (69) 1 ☐ Yes 0 ☐ No 9 ☐ Unk. _____ (70-71)

14. Did the patient travel or live outside the United States during the 30 days before the illness began? (72) 1 ☐ Yes 0 ☐ No 9 ☐ Unk.

If Yes, please list in order the countries visited during the 30 days before the illness began: (other than the United States)
1. _____ (73-88)
2. _____ (89-104)
3. _____ (105-120)
4. _____ (121-136)

Date of most recent return or entry to the United States: Mo. _____ Day _____ Yr. _____ (137-142)

15. Was the purpose of the international travel:
- **a.)** Business? (143) 1 ☐ Yes 0 ☐ No 9 ☐ Unk.
- **b.)** Tourism? (144) 1 ☐ Yes 0 ☐ No 9 ☐ Unk.
- **c.)** Visiting relatives or friends? (145) 1 ☐ Yes 0 ☐ No 9 ☐ Unk.
- **d.)** Immigration to U.S.? (146) 1 ☐ Yes 0 ☐ No 9 ☐ Unk.
- **e.)** Other? (147) 1 ☐ Yes 0 ☐ No 9 ☐ Unk.

(if other, specify): _____ (148-164)

16. Was the case traced to a typhoid carrier? (165) 1 ☐ Yes 0 ☐ No 9 ☐ Unk.

If Yes, was the carrier **previously known** to the health department? (166) 1 ☐ Yes 0 ☐ No 9 ☐ Unk.

17. Comments:

18. Name of Person Completing Form: _____

Address: _____

Telephone: (_____) _____ Date: Mo. _____ / Day _____ / Yr. _____

– THANK YOU VERY MUCH FOR TAKING THE TIME TO COMPLETE THIS FORM –

Please send a copy to your STATE EPIDEMIOLOGY OFFICE ***and*** the
FOODBORNE AND DIARRHEAL DISEASES BRANCH, CENTERS FOR DISEASE CONTROL AND PREVENTION,
Mailstop A-38, Atlanta, Georgia, 30333. • Fax: (404) 639-2205